MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

63-037640

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9431 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB — AMENDED

VS 300 Rev. 4/59

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

1
2 21 2
3 2
4 3
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90

USE BLACK INK OR TYPEWRITER RIBBON

BY AFFIDAVIT OF DOCUMENT

FILED SEP 26 1963

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, | Length of stay in 1b

c. CITY OR TOWN St. Louis | Inside Limits Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5070 Cabanne Ave., | Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 5070 Cabanne Ave., | Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Virginia Middle Last Henderson

4. DATE OF DEATH Month Sept. Day 20, Year 1963

5. SEX Female

6. COLOR OR RACE Negro

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH 2-10-1904

9. AGE (last birthday) 59 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) Tennessee

12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Will Peden

13b. MOTHER'S MAIDEN NAME Unknown

14. NAME OF HUSBAND OR WIFE Will Henderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of servi

16. SOCIAL SECURITY NO.

17. INFORMANT Address Mrs Mabel Queen 5070 Cabanne Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Hypertensive Heart Disease Lyn — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c) 443 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 8/3/63 to 9/20/63 and last saw her/him alive on 9/20/63
Death occurred at 12 50 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Dewey C. Turner MD

22b. ADDRESS 1423 N Grand St Louis MO

22c. DATE SIGNED 9/20/63

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 9-20-63

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county) Cotton Plant, Ark. (State)

24. FUNERAL DIRECTOR ADDRESS G. Wade Granberry 4202 Finney Ave.

25. DATE RECD. BY LOCAL REG. SEP 20 1963

26. REGISTRAR'S SIGNATURE Read Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Edward A. Tyman

Licensed Embalmer No. 4444

P. O. Address 4202 Finney Ave.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.